Patient Sleep Questionnaire

Name_____ Marital Status: S M W D
Last First Middle

Address_____City_____State_____Zip Code_____

Home Phone # _____Emergency #_____Cell #: _____ Date of Birth_____ Age: ___

Employed By: _____ Occupation_____ Social Security #_____

Business Address: _____ City _____State _____ Zip Code_____

Business Phone#: _____ Fax #: _____ E-mail: _____

*Medical Insurance Carrier, Self*_____ Group #:_____

Dental Insurance Carrier, Self_____ Group #:_____

Spouse's Name_____ Date of Birth_____

Spouse Employed By: _____ Occupation: _____ Social Security # _____

Spouse's Business Address: _____ City _____ State _____ Zip Code_____

Spouse's Business Phone# _____ Fax # _____ E-mail_____

*Spouse's Medical Insurance Carrier*_____ Group #: _____

Spouse's Dental Insurance Carrier_____ Group #: _____

Referred to Dr. Carollo's office by: _____

Medical History: *Please Write Your Answers As Complete As Possible; All Information Is Confidential*

Physician's Name Address and Phone #: _____

_____

Sleep Physician or Pulmonologist's Name Address and Phone #: _____

_____

Height _____ Weight _____ Weight gain or loss, (10 lbs or more): Yes / No

My normal work hours / days are: _____

1. Are you presently under the care of a physician? _____Date of last Exam_____
   If Yes, for what condition? _____
2. Has there been any change in your general health within the past year?_____ Explain_____
3. Have you ever had a serious Illness? _____ If Yes, Please Explain_____
4. Are you presently taking any medications? _____ Please Identify and explain need:_____
   _____
5. Have you ever had high blood pressure? _____ or low blood pressure? _____
6. Have you ever had Heart Disease? Angina? Heart Attack? Congestive Heart Failure? _____ When? _____
7. Have you ever had Diabetes? _____ If yes, date of onset _____

(over)

8. Have you had Bypass Surgery? _____ When? _____

9. Have you ever had Asthma, Bronchitis, or Emphysema? _____ When? _____

10. Have you ever had Tonsillectomy or Adenoidectomy? _____When? _____

11. Have you ever had a Stroke? _____ When? _____

12. Do you smoke? _____ Number of packs per day? _____

13. Have you ever had Hiatal Hernia or Acid Reflux? _____

14. Have you had any recent surgeries? Please list: _____

Sleep History: *These questions help us understand your sleep habits better*

My complaint(s) is (are):	I have experienced these symptoms for:				
☐ Snoring	☐ 1-18 months	☐ 19 months to 5 yrs.	☐ 6-10 yrs.	☐ 11-20 years	☐ 20+ yrs.
☐ My Breathing Stops	☐ 1-18 months	☐ 19 months to 5 yrs.	☐ 6-10 yrs.	☐ 11-20 years	☐ 20+ yrs.
☐ I'm sleepy	☐ 1-18 months	☐ 19 months to 5 yrs.	☐ 6-10 yrs.	☐ 11-20 years	☐ 20+ yrs.
☐ I can't fall asleep or stay asleep	☐ 1-18 months	☐ 19 months to 5 yrs.	☐ 6-10 yrs.	☐ 11-20 years	☐ 20+ yrs.
☐ I talk or walk in my sleep	☐ 1-18 months	☐ 19 months to 5 yrs.	☐ 6-10 yrs.	☐ 11-20 years	☐ 20+ yrs.
☐ Other, please comment: _____					

1. How long does it take you to fall asleep? _____ minutes _____ hours
2. On average, how many times do you awake during the night? _____ times. How long are you awake? _____
3. Workday bedtime: _____ Wakeup time: _____
4. Day off Bedtime: _____ Day off wakeup time: _____

Please answer these questions using our number scale; circle your choice:

1 = rarely less than once a month	2 = sometimes 1-3 times a month	3 = often 4-8 times a month	4 = frequently 3-4 times a week	5 = always 5-7 times a week

5.	No matter how much I sleep I get, I wake up feeling tired:	No	1	2	3	4	5
6.	If you were able to sleep longer would you feel rested?	No	1	2	3	4	5
7.	So you have a problem with your work performance because you are sleepy or tired?	No	1	2	3	4	5
8.	Have you fallen asleep at work?	No	1	2	3	4	5
9.	Do you take regular naps?	No	1	2	3	4	5
10.	Do you feel sleepy when driving?	No	1	2	3	4	5
11.	Does your snoring disturb others?	No	1	2	3	4	5
12.	Have you been told you hold your breath or gasp for air when sleeping?	No	1	2	3	4	5
13.	I wake up short of breath or gaping?	No	1	2	3	4	5
14.	I have a problem falling asleep and sleeping a full night?	No	1	2	3	4	5
15.	My legs seem to move or kick during my sleep at night?	No	1	2	3	4	5
16.	Do you clench or grind your teeth during the night?	No	1	2	3	4	5
17.	Have you ever had a sleep study before?	No	1	2	3	4	5
18.	Do you have relatives with sleep disorders?	No	1	2	3	4	5
19.	Do you have and significant stress in your life at the present time?	No	1	2	3	4	5

I certify that the above information has been answered to the best of my ability.

Patient's signature_____ Date: _____